Commonwealth of Kentucky
Personnel Cabinet
Department for Employee Insurance

Dependent Add Form

This form must be used for any qualifying event (QE) that allows you to add dependents to your plan. Complete a Health Insurance Application for election changes such as moving out of the service area or if previously waived coverage and now selecting coverage.

Applicant's SSN ☐☐☐-☐☐-☐☐☐☐

Retiree's SSN (if applicable) ☐☐☐-☐☐-☐☐☐☐

Company Number ☐☐☐☐☐

Name (First, MI, Last) **(PRINT)** _____ Date of Birth (MM/DD/YYYY) _____

To be eligible to add a dependent to your health insurance plan, you must certify that you have experienced the QE as listed here. The QEs listed on this form are the only events that allow you to add dependents to your plan. To be considered an eligible dependent, your dependent MUST be one of the following: (Check One)

- ☐ your legal spouse; or
- ☐ your unmarried child, stepchild, adopted child, or foster child; or
- ☐ an unmarried grandchild or other child under the age of 24 for whom you have legal guardianship.

In addition, your dependent child MUST meet ALL of the following eligibility requirements *(**MUST check all that apply to certify eligibility**)*:

- ☐ is under the age of 24; and
- ☐ depends on the employee for more than 50% of his/her support and maintenance; and
- ☐ lives in the employee's household in a parent-child relationship (unless you have a Court Order or an Administrative Order to provide health coverage for the child).

Qualifying Events: (Check one)

- ☐ Birth - newborn only (60 days)
- ☐ Birth plus other dependents (30 days)
- ☐ Adoption*/Placement* - adopted/placed child only (60 days)
- ☐ Adoption*/Placement* - adopted/placed child plus other (30 days)
- ☐ Legal guardianship*, administrative order*, court order*
- ☐ Marriage
- ☐ Spouse/Retiree's Death (if it causes loss of other coverage*)
- ☐ Spouse/Retiree has different open enrollment period*
- ☐ Loss of other employer group coverage*
- ☐ Loss of governmental group coverage*
- ☐ Unmarried dependent re-establishes eligibility
- ☐ Significant cost increase (*Dependent Care changes ONLY*)
- ☐ Spouse/Dependent begins LWOP
- ☐ Other: _____

Qualifying Event Date (mm/dd/yy): _____

**** Supporting documentation is required.***

PRINT the following information for each dependent to be added:

Social Security Number	Name (First, MI, Last)	Gender (Circle one)	Date of Birth (MM/DD/YYYY)	Relationship Code**
		M F		
		M F		
		M F		
		M F		

** Relationship Code: SP=Spouse CH=Child DD=Disabled Dependent CO=Court Ordered Dependent

Applicable to employees of State Agencies ONLY (Commonwealth Choice). All other employees must contact their Insurance Coordinator for specific information about the employer's Flexible Spending Account Program. Retirees are not eligible to participate in an FSA.

Healthcare Spending Account

I request a change in my "per check" deduction

from $_____ to $_____ employee money

from $_____ to $_____ employer money

☐ **< YES, I wish to enroll in the EZ Reimburse Debit Card plan.** I understand that if I enroll, there is a $6 annual fee and a $0.50 charge per transaction.

Dependent Care Account

Check your Tax Filing Status:

- ☐ < Married, filing separately - $104 max per paycheck
- ☐ < Married, filing jointly - $208 max per paycheck
- ☐ < Single, head of household - $208 max per paycheck

I request a change in my "per check" deduction

from $_____ to $_____ employee money

My signature below certifies that I understand the statements on this form and that all the information provided by me is true and complete to the best of my knowledge. I understand that any person who knowingly and with intent to defraud any insurance company or other person, files this form containing any materially false information or conceals, with the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime. I understand that any material misrepresentation or material omission contained herein may be used to void this contract.

_____ Applicant Signature _____ Date _____ Insurance Coordinator Signature _____ Date

_____ Retiree Signature _____ Date

Signatures below are REQUIRED if you are currently paying by cross-reference. If you wish to START paying by cross-reference, you MUST complete a health insurance application.

_____ Spouse Signature _____ Date _____ Spouse's Insurance Coordinator Signature _____ Date

WHITE -Enrollment Information Branch PINK - Employer/Retirement System CANARY - Employee/Retiree Revision Date: 4-15-2005